



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Shannon Clinic

**Respondent Name**

American Zurich Insurance Co

**MFDR Tracking Number**

M4-17-2545-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

April 26, 2017

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "We took back to coding who states the code and modifiers are correct. We are looking for final adjudication on this matter."

**Amount in Dispute:** \$160.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

**Response Submitted by:** Flahive, Ogden & Latson

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 4, 2017	97164	\$160.00	\$0.00

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 236 – This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the NCCI or workers compensation state regulations/fee schedule requirements

- W3 – In accordance with TDI-DSW rule 134.804, this bill has been identified as a request for reconsideration or appeal

### **Issues**

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

### **Findings**

1. The requestor is seeking reimbursement of \$160.00 for code 97164 – “Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family” rendered on January 4, 2017.

The insurance carrier denied disputed services with claim adjustment reason code 236 – “This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the NCCI or workers compensation state regulations/fee schedule requirements.”

28 Texas Administrative Code §134.203 (b) states in pertinent part,

For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

- (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

Review of the 2017 National Correct Coding Initiative Policy Manual, Chapter 11 – CPT Codes 90000 – 99999, Section P, found at <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html> finds the following,

*2. NCCI contains PTP edits with column one codes of the physical medicine and rehabilitation therapy services and column two codes of the physical therapy and occupational therapy re-evaluation CPT codes of 97164 and 97168 respectively. The re-evaluation services should not be routinely reported during a planned course of physical or occupational therapy. However, if the patient's status should change and a re-evaluation is medically reasonable and necessary, it may be reported with modifier 59 appended to CPT code 97164 or 97168 as appropriate.*

Review of the submitted medical claim line for code 97164 finds only the use of the “GP” modifier. Therefore the carrier's denial is supported. No additional payment is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

### **Authorized Signature**

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Signature

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Medical Fee Dispute Resolution Officer

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May 19, 2017  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**